

**Maine Bureau of Insurance**  
**Form Filing Review Requirements Checklist**  
**Group Supplemental Health (H21)**  
**Revised 6/4/2015**

Confirm compliance and IDENTIFY the LOCATION (page number, section, paragraph, etc.) of the STANDARD IN FILING in the last column. If a contract does not have to meet this requirement please EXPLAIN WHY in the last column.

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	CONFIRM COMPLIANCE AND IDENTIFY LOCATION OF STANDARD IN FILING <b>AND EXPLAIN IF REQUIREMENT IS INAPPLICABLE</b>
<b>GENERAL SUBMISSION REQUIREMENTS</b>			
Electronic (SERFF) Submission Requirements	<a href="#"><u>24-A M.R.S.A. §2412 (2) Bulletin 360</u></a>	All filings must be filed electronically, using the <u>NAIC System for Electronic Rate and Form Filing (SERFF)</u> . See <a href="http://www.serff.com"><u>http://www.serff.com</u></a> .	
FILING FEES	<a href="#"><u>24-A M.R.S.A. §601(17)</u></a>	\$20.00 for Rate filings, rating rules filings, insurance policy, forms, riders, endorsements and certificates. See General Instructions page in SERFF for additional information on filing fee structure. Filing fees must be submitted by EFT in SERFF at the time of submission of the filing. All filings require a filing fee unless specifically excluded per 24-A M.R.S.A. §4222(1), and/or are a required annual report.	
Grounds for disapproval	<a href="#"><u>24-A M.R.S.A. §2413</u></a>	Seven categories of the grounds for disapproving a filing.	
Readability	<a href="#"><u>24-A M.R.S.A. §2441</u></a>	Minimum of 50. Riders, endorsements, applications all must be scored. They may be scored either individually or in conjunction with the policy/certificate to which they will be attached. Exceptions: Federally mandated forms/language, Groups > 1000, Group Annuities as funding vehicles. Scores must be entered on form schedule tab in SERFF.	

Variability of Language	<a href="#">24-A M.R.S.A. §2412</a> <a href="#">§2413</a>	Forms with variable bracketed information must include all the possible language that might be placed within the brackets. The use of too many variables will result in filing disapproval as Bureau staff may not be able to determine whether the filing is compliant with Maine laws and regulations.	
<b>GENERAL POLICY PROVISIONS</b>			
AIDS	<a href="#">24-A M.R.S.A. §2846</a>	May not provide more restrictive benefits for expenses resulting from Acquired Immune Deficiency Syndrome (AIDS) or related illness.	
Calculation of health benefits based on actual cost	<a href="#">24-A M.R.S.A. §2185</a>	Policies must comply with the requirements of 24-A §2185 which requires calculation of health benefits based on actual cost. All health insurance policies, health maintenance organization plans and subscriber contracts or certificates of nonprofit hospital or medical service organizations with respect to which the insurer or organization has negotiated discounts with providers must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any discounts or differentials from charges otherwise applicable to the services provided. With respect to policies or plans involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or organization is finalized.	
Child coverage	<a href="#">24-A M.R.S.A. §2833</a>	Defined as under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with the policyholder, member or spouse of the policyholder or member, no financial dependency requirement, court ordered coverage	
Childhood Immunizations	<a href="#">24-A M.R.S.A.</a>	Childhood immunizations must be expressly covered or	

	<a href="#">§4302(1)(A)(5)</a>	expressly excluded in all policies. If childhood immunizations are a covered benefit it must be expressly stated in the benefit section. If childhood immunizations are not a covered benefit then this must be expressly stated as an exclusion in the policy.	
Classification, Disclosure, and Minimum Standards	<a href="#">Rule 755</a>	Must comply with all applicable provisions of Rule 755 including, but not limited to, Sections 4, 5, 6(A), 6(L), 7(A), 7(B), and 7(M)	
Coordination of benefits	<a href="#">24-A M.R.S.A. §2844</a>	Medicaid is always secondary	
Coverage for Dental Hygienists	<a href="#">24-A M.R.S.A. §2847-Q</a>	Coverage must be provided for dental services performed by a licensed independent practice dental hygienist when those services are covered services under the contract and when they are within the lawful scope of practice of the independent practice dental hygienist.	
Coverage for Dependent Children Up to Age 25	<a href="#">24-A M.R.S.A. §2833-B</a>	<p>A group health insurance policy that offers coverage for dependent children must offer such coverage until the dependent child is 25 years of age. Pursuant to §2833-B the child must be unmarried, have no dependent of their own, be a resident of Maine or be enrolled as a full-time student, and not have coverage under any other health policy/contract or federal or state government program.</p> <p>An insurer shall provide notice to policyholders regarding the availability of dependent coverage under this section upon each renewal of coverage or at least once annually, whichever occurs more frequently. Notice provided under this subsection must include information about enrolment periods and notice of the insurer's definition of and benefit limitations for preexisting conditions.</p>	
Designation of Classification of Coverage	<a href="#">Rule 755, Sec. 6</a>	The heading of the cover letter of any form filing subject to this rule shall state the category of coverage set forth in 24-A M.R.S.A. § 2694 and Rule 755 that the form is intended to be in.	
Explanations for any Exclusion of Coverage for	<a href="#">24-A M.R.S.A. §2413</a>	If the policy excludes coverage for work related sicknesses or injuries, clearly explain whether the	

work related sicknesses or injuries		coverage is excluded if the enrollee is exempt from requirements from state workers compensation requirements or has filed an exemption from the workers compensation laws.	
Explanations Regarding Deductibles	<a href="#">24-A M.R.S.A. §2413</a>	All policies must include clear explanations of all of the following regarding deductibles: <ol style="list-style-type: none"> <li>1. Whether it is a calendar or policy year deductible.</li> <li>2. Clearly advise whether non-covered expenses apply to the deductible.</li> <li>3. Clearly advise whether it is a per person or family deductible or both.</li> </ol>	
Extension of Benefits (as applicable)	<a href="#">24-A M.R.S.A. §2849-A</a>	Must provide an extension of benefits of at least 6 months for a person who is totally disabled on the date the group or subgroup policy is discontinued. For a policy providing specific indemnity during hospital confinement, "extension of benefits" means that discontinuance of the policy during a disability has no effect on benefits payable for that confinement.	
Extension of coverage for dependent children with mental or physical illness	<a href="#">24-A M.R.S.A. §2833-A</a>	Requires health insurance policies to continue coverage for dependent children up to 24 years of age who are unable to maintain enrollment in college due to mental or physical illness if they would otherwise terminate coverage due to a requirement that dependent children of a specified age be enrolled in college to maintain eligibility.	
Lifetime Limits and Annual Aggregate Dollar Limits Prohibited	<a href="#">§4318</a>	An individual or group health plan may not include a provision in a policy, contract, certificate or agreement that purports to terminate payment of any additional claims for coverage of health care services after a defined maximum aggregate dollar amount of claims for coverage of health care services on an annual, lifetime or other basis has been paid under the health plan for coverage of an insured individual, family or group.  A carrier may however offer a health plan that limits	

		benefits under the health plan for specified health care services on an annual basis.	
Limits on priority liens	<a href="#">24-A M.R.S.A. §2836</a>	A policy may contain a provision that allows such payments, if that provision is approved by the superintendent, and if that provision requires the prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien. A just and equitable basis shall mean that any factors that diminish the potential value of the insured's claim shall likewise reduce the share in the claim for those claiming payment for services or reimbursement.	
Mandated/Required Provisions	<a href="#">Rule 755, Sec. 9(G)</a> <a href="http://www.maine.gov/pfr/insurance/consumer/mandated_benefits.htm">http://www.maine.gov/pfr/insurance/consumer/mandated_benefits.htm</a>	<p>A supplemental plan is not considered a limited benefit plan if, in the judgment of the Superintendent, it is substantially similar to one of the following types of insurance:</p> <ul style="list-style-type: none"> <li>- Basic Hospital Expense Coverage – as defined in Rule 755, Sec. 6(B)</li> <li>- Basic Medical-Surgical Expense Coverage – as defined in Rule 755, Sec. 6(C)</li> <li>- Basic Hospital/Medical-Surgical Expense Coverage – as defined in Rule 755, Sec. 6(D)</li> <li>- Major Medical Expense Coverage – as defined in Rule 755, Sec. 6(F)</li> <li>- Basic Medical Expense Coverage – as defined in Rule 755, Sec. 6(G)</li> </ul> <p>If the supplemental plan is substantially similar to any of the above listed types of insurance then it must contain all required mandated benefits and other requirements of Maine insurance law applicable to that particular type of insurance. (See appropriate checklist)</p>	
Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies	<a href="#">24-A M.R.S.A. §5013, Rule 275, Sec. 17(E)</a>	There must be a notice predominantly displayed on the first page of the policy that states: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the	

		company."	
Notification prior to cancellation	<a href="#">24-A M.R.S.A. §2847-C, Rule 580</a>	10 days prior notice, reinstatement required if insured has an organic brain disorder	
Penalty for failure to notify of hospitalization	<a href="#">24-A M.R.S.A. §2847-A</a>	No penalty for hospitalization for emergency treatment	
Penalty for noncompliance with utilization review	<a href="#">24-A M.R.S.A. §2847-D</a>	penalty of more than \$500 for failure to provide notification under a utilization review program	
Preventative Care Services	<a href="#">24-A M.R.S.A. §4320-A</a>	Coverage of preventive health services	
Renewal provision	<a href="#">24-A M.R.S.A. §2738</a>	Policy must contain the terms under which the policy can or cannot be renewed.	
Representations on Applications	<a href="#">24-A M.R.S.A. §2818</a>	There shall be a provision that all statements contained in any such application for insurance shall be deemed representations and not warranties.	
Required provisions	<a href="#">24-A M.R.S.A. §2816</a>	Application statements, notice of claim, proof of loss, assignment of benefits	